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Supreme Court, U.S.
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No.

In the
Supreme Court of the United States

MARY GLENN, ERNEST JACKSON, LORI MARSHALL and LANE GLENN,

Petitioners,

versus

LIFE INSURANCE COMPANY OF NORTH AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether an insurance company that both funds and administers benefits under an ERISA plan is acting under a conflict that warrants a less deferential standard of review.

2. Whether when an ERISA plan beneficiary demonstrates a conflict of interest on the part of the plan administrator, the standard of review of the decision of the administrator is based on:

a) a de novo review of the decision;

b) a presumption that the decision was arbitrary and capricious unless the administrator can show under de novo review that the decision was correct or not made to serve a conflicting interest or;

c) a sliding scale approach relating to the seriousness of the conflict to the amount of deference given to the decision.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit is reported at 240 F.3d 679. (App. 1a). The opinion of the District Court for the Western District of Missouri is reported at 76 F.Supp.2d 992. (App. 7a).

JURISDICTION

The judgment of the United States Court of Appeals of the Eighth Circuit affirming the decision of the District Court of the Western District of Missouri was entered on February 12, 2001. (App. 1a). The Court entered an order extending the time to file a Petition for Rehearing and Rehearing En Banc until March 12, 2001. (App. 24a). The Court entered an order denying the Petition for Rehearing and Rehearing En Banc on April 23, 2001. (App. 23a). This petition for writ of certiorari is filed within ninety (90) days from that date.

The jurisdiction of the Court is invoked pursuant to the provisions of 28 U.S.C. Section 1254(1).

STATUTORY PROVISIONS INVOLVED

29 U.S.C. Sec. 1002(21)(A)

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (I) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with

respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administrator of such plan Such term includes any person designated under section 1105(c)(1)(B) of this title.

29 U.S.C. §1132 Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. §1133. Claims Procedure

In accordance with regulations of the Secretary, every employee benefit plan shall -

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. (Sept. 2, 1974, P.L. 93-406, Title I, Subtitle B, Part 5, § 503, 88 Stat. 893.)

STATEMENT OF THE CASE

Robert Jackson was found dead on January 10, 1995, at his home in Missouri as a result of a single gunshot wound to the head. Mr. Jackson had worked for Hallmark Cards, Inc. ("Hallmark"), since 1974 and was insured under a policy of insurance issued to Hallmark by the Life Insurance Company of North America ("LINA"). In December 1996 Petitioners filed suit in the Circuit Court of Jackson County, Missouri. LINA removed the case to federal court on March 7, 1997 pursuant to 29 U.S.C. §1132(a)(1)(B). The parties filed a joint motion to stay the proceedings to permit additional time for review of the plan administrator's decision. Pursuant to the group Voluntary Accident Plan ("Plan"), Hallmark made death and dismemberment coverage available to its employees. The Plan documents consisted of the Plan, the Group Life Insurance Policy No. 0K6226 issued to Hallmark by LINA, and a summary plan description. The policy has an exclusion of benefits for self-inflicted injuries which are incurred by a sane person in Missouri. This exclusion does not apply to injuries caused by one who is not sane at the time of the injury. Hallmark and its welfare committee are the Plan Administrator under the Plan for the purpose of the Employee Retirement Income Security Act. Hallmark delegated discretionary authority to LINA to determine eligibility for benefits. At the suggestion of employees of Hallmark's Employee Benefits Department, Mary Glenn, Ernest Jackson, Lori Marshall and Lane Glenn filed a claim for the death benefits of Robert Jackson's policy on February 27, 1995. Mary Glenn, on behalf of the other beneficiaries, wrote to Michael Jackson, the Senior Benefit Analyst for LINA, and stated their belief that Robert Jackson could not have been of sane mind when he died. Authorizations were provided by the beneficiaries to LINA

for the insurer to acquire any information necessary to fully investigate their claim.

Michael Jackson, on behalf of LINA, denied their claim on May 25, 1995. The claim form submitted by the beneficiaries was in proper order and they are eligible to be paid the proceeds of the policy except for the exclusion claimed by the insurance company/plan administrator. The initial denial stated there was no evidence that Mr. Jackson was not sane at the time of his death and therefore his claim is excluded. No independent medical review of the file was ever conducted. The personnel file of Mr. Jackson was not requested until October 22, 1996.

The denial letter informed the beneficiaries that they could request a review of the denial decision and they would be notified of the decision no later than 120 days after the request was received. Mary Glenn sent a request for review on July 19, 1995 and stated the belief that Robert Jackson's mental status at the time of his death was unsound and that conditions of his employment caused his death. LINA requested petitioners to provide names and addresses of witnesses they believed would support their claim in July of 1995 and followed up on the letter in October of 1996.

On September 30, 1997 Dr. William Logan reported on behalf of the petitioners that after thorough investigation he concluded that Mr. Jackson could not exercise a rational judgment on the question of life or death and had a preoccupation with killing himself that constituted a morbid impulse. Mr. Jackson experienced suicidal thoughts that became a compulsion. Dr. Logan's complete findings were submitted to LINA, as they had requested any additional information to support the petitioners' claim.

The attorney retained to defend LINA in the pending lawsuit hired Dr. Bruce Harry to rebut Dr. Logan's findings. On March 2, 1998 Dr. Harry reported his conclusions to LINA. Dr. Harry has no criticism of Dr. Logan's analysis. Dr. Harry picked thirteen factors he opined indicated Robert Jackson had a deranged condition of the mind and twenty-one factors he opined indicated that Mr. Jackson did not have a deranged condition of the mind. The doctor concluded that, on balance, to a reasonable degree of medical certainty that Mr. Jackson did not have a deranged condition of the mind at the time he took his own life. The doctor then chose four factors that he stated indicated Mr. Jackson was insane when he took his own life and sixteen factors that he stated indicated that Robert Jackson was not insane.

John Taylor, the LINA representative in charge of this review has conducted hundreds of ERISA reviews but has never referred out the review of a case to an independent reviewer. LINA could have requested an independent company such as UNIVAL to review this claim but did not do so. Neither John Taylor nor Dr. Harry have any criticism of the findings submitted by Dr. Logan on behalf of petitioners, indicating Mr. Jackson was not sane at the time of his death.

Proceedings Below

LINA filed its Motion for Summary Judgment on September 22, 1998 in the United States District Court of the Western District of Missouri. The Honorable D. Brook Bartlett granted the Summary Judgment Motion on November 15, 1999. On December 14, 1999 the Petitioners filed their Notice of Appeal to the Eighth Circuit Court of Appeals.

On February 12, 2001 the Court of Appeals affirmed. The Court concluded that when the insurance company that benefits financially from the claim's denial is also the ERISA plan administrator, a less deferential standard of review may apply. (App. 2a). The court further ruled that to obtain a less deferential standard, the beneficiaries must first show a serious breach of fiduciary duty and that the petitioners failed to do so. (App. 2a).

In his dissent, Judge Bye stated he believes a less deferential standard of review should apply. (App. 4a) Judge Bye reasoned that the majority set a dangerous precedent in allowing an administrator under a conflict of interest to resort to the testimony of an adversarial litigation expert to justify an earlier, initial benefits denial. It was further noted that fiduciaries are not normally permitted to act in such a manner. As a result of the plan administrator's conflict, Judge Bye would require substantial evidence, bordering on a preponderance to uphold the Company's decision. (App. 5a).

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW MAGNIFIES THE CONFLICT BETWEEN THE COURTS OF APPEALS REGARDING THE DEFERENCE TO BE GRANTED TO THE REVIEW OF A DENIAL OF ERISA BENEFITS MADE BY A PLAN ADMINISTRATOR WHO ALSO PAYS THESE BENEFITS OUT OF ITS OWN FUNDS.

The Third Circuit Court of Appeals recently issued an opinion denoting the conflict and confusion among the Court of Appeals. This conflict is in regard to the standard courts should use when reviewing a denial of benefits

under an ERISA plan by an insurance company which determine both eligibility for benefits and pays also those benefits out of its own fund. *Pinto v. Reliance Standard_Life Ins. Co.*, 214 F.3d 377, 378 (3rd.Cir. 2000). According to the Third Circuit, "This question, and variations thereof, have bedeviled the federal courts since considered dicta in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 . . ., gave opaque direction about how courts should review discretionary benefits denials by potentially conflicted ERISA fiduciaries." Id. In *Firestone*, the Court instructed that a conflict of interest should be "weighed as a 'factor' in determining whether there is an abuse of discretion." Id. at 109. The Third Circuit further noted that "since *Firestone*, courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto* at 383. The Third Circuit in *Pinto* then divided the Courts of Appeal into three categories. Id. 384-86. The Court found that several court of appeals conclude that there is an inherent conflict of interest when an insurance company both administers and pays out benefits under an ERISA plan. Id. at 384. The court also found that several courts of appeals conclude that there is no conflict present under these circumstances which should affect the standard of review of a benefits decision. Id. at 384-85. The *Pinto* court also found several courts of appeal in which the law is unclear and unsettled as to how to approach this issue of review under these circumstances. Id. at 386-87.

The Third Circuit Court determined heightened scrutiny is required when an insurance company is both the plan administrator and funder of the plan. Id. at 387. The Court stated ". . . ERISA litigation generally arises only in

close cases, and there would seem to be insufficient incentive for the carrier to treat borderline cases (unlikely to become causes celebres) with the level of attentiveness and solicitude that Congress imagined when it created ERISA 'fiduciaries'". Id. at 388. Incredulously, the Third Circuit found the Eighth Circuit as one of the most persuasive on this issue of the application of heightened scrutiny. Id. at 387. This is by far the best evidence of the conflict and confusion in the courts regarding this issue. Quite clearly, the Eighth Circuit refused to apply heightened scrutiny in the Petitioners' case in which not only was the plan administrator the insurer but there was strong evidence of self-dealing. For this reason the Eighth Circuit should be grouped with the Sixth and Ninth Circuits in which the law on this issue is unclear and unsettled.

The Fourth Circuit Court of Appeals has held that a conflict is inherent from the nature of the relationship in a situation where the ERISA plan administrator serves both the insurance company and as fiduciary to the beneficiaries. *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993). The Fifth Circuit Court of Appeals concluded that the risk of the insurance company's reputation through denial of meritorious claims was outweighed by the strong incentive to self-deal. *Vega v. Nat'l Life Ins. Serv. Inc.*, 188 F.3d 287, 295-298 (5th Cir. 1999). The Tenth Circuit has found that the conflict warrants a more searching review of the denial determination. *Pitman v. Blue Cross and Blue Shield of Okla.*, 24 F.2d 118, 123 (10th Cir. 1994). The Eleventh Circuit found "an inherent conflict between the roles assumed by an insurance company that administers claims under a policy it issued . . . Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit making role as a business."

Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556, 1561 (11th Cir. 1990).

The Second and Seventh Circuits use similar reasoning in their determination of how to best deal with this issue of conflict of interest. The Second Circuit requires evidence that a conflict actually affected the decision of the ERISA plan administrator prior to the application of anything but the most deferential standard of review of the fiduciary's determination. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2d. Cir. 1996). The Seventh Circuit "presume(s) that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir.), cert. denied, 119 S.Ct. 372 (1998).

The Courts have cried out for guidance from this Court in the form of an authoritative opinion as to the deference to be granted to the review of a denial of ERISA benefits made by a plan administrator who also pays these benefits. The United States District Court for the District of New Jersey recently summed up its frustration with the conflict and confusion regarding this issue by stating that "Bruch, having identified the problem, conspicuously failed to offer guidance in evaluating the benefits decisions of such conflicted fiduciaries." *Lasser v. Reliance Standard Life Ins. Co.*, 130 F.Supp. 2d 616, 620 (D.N.J. 2001). There is no way to reconcile the conflicts which are found both between Circuits and within Circuits regarding this issue. This case accordingly merits the Court's immediate review.

II. THE EIGHTH CIRCUIT COURT OF APPEALS FAILED TO WEIGH AS A FACTOR THE CONFLICT OF INTEREST WHICH THE ERISA PLAN ADMINISTRATOR WAS ACTING UNDER WHILE SERVING HIS DUAL ROLE AS PAYOR OF BENEFITS FROM THE INSURANCE COMPANY FUNDS AND FIDUCIARY TO THE BENEFICIARIES.

The Eighth Circuit applied an incorrect standard of review to the decision of the plan administrator in the Petitioners' case. The Court failed to use a less deferential standard to determine the correctness of the plan administrator's decision. (App. 2a). The court did acknowledge that the insurance company that benefits financially from the denial of the petitioners' claim is also the ERISA plan administrator. (App. 2a). The Court stopped short of recognizing the conflict of the plan administrator.

The Court in *Bruch* stated "that conflict must be weighed as a 'factor' in determining whether there is an abuse of discretion." *Bruch* at 109 citing Restatement (Second) of Trusts §187 (1959). Even that small amount of guidance was ignored by the majority in the petitioners' case.

The Eighth Circuit would require the Petitioners to show that the conflict so tainted the process that it caused a serious breach of fiduciary duty. The facts in this case are the same as facts in similar cases throughout all of the circuits. The plan administrator both funds the plan and determines benefit decisions. The conflict is inherent and the review must reflect that conflict. Additionally, LINA "should be required to obtain a truly independent, outside

medical opinion about Robert Jackson's sanity before making a benefits determination." (App at 6a). LINA's initial decision to deny benefits was based solely on an in-house review of Jackson's medial records. (App. 5a). The ultimate decision was based on the opinion of Dr. Harry, an expert hired to defend their poorly decided initial decision in the adversarial context of litigation. Even so, neither Dr. Harry nor the plan administrator had anything derogatory to note about the opinion provided initially by Dr. Logan, the Petitioners' medical reviewer. Should this opinion be allowed to stand, this case will stand for the proposition that conflicted ERISA plan administrators have a wild card. Their initial benefits decision will be played as a joker. Insurance companies nationwide will realize that they too will be able to bolster their decision with evidence bought and paid for up to three years after their initial decision , and still not lose any of their discretion in making these decisions regardless of the conflicts present. Clearly the lower courts are in need of guidance on this issue. The application of the law from circuit to circuit and even within circuits, is making it impossible for the courts to determine how to apply the law in their own jurisdictions, let alone for the litigants to have any expectation of protection under the law. The Eighth Circuit decision should be reversed to avoid the serious consequence of such a precedent.

III. THE CONFLICT AND CONFUSION IN THE COURTS AS TO WHAT STANDARD OF REVIEW TO APPLY TO THE REVIEW OF A CONFLICTED ERISA PLAN ADMINISTRATOR'S DENIAL OF BENEFITS DECISION IS A MATTER OF GREAT IMPORTANCE ABOUT WHICH THE LOWER COURTS HAVE SOUGHT GUIDANCE FROM THIS COURT.

There is nothing but conflict and confusion between and among the circuit courts as to what standard of review to apply and how to apply it to the review of a conflicted ERISA plan administrator's denial of benefits decision. Again, the Third Circuit has recently discussed various attempts by various circuits to develop what that circuit believes to be the correct standard of review. Unfortunately, even the circuits which are able to agree among themselves as to the title of the standard of review they apply, most often do not agree on the manner by which to actually apply the standard. The lower courts are badly in need of guidance by this court in order to provide unity and dispel the conflicts between and within the Circuit Courts.

The First, Third, Fourth, Fifth, Sixth, Tenth and the Eight Circuits all fall somewhere under the broad "sliding scale" standard. *Pinto* at 391-92. The Second Circuit has adopted a two part test which mirrors §187 of the Restatement (Second) of Trusts. *Sullivan* at 1255. The first part of this test is the determination of whether the final decision was reasonable and, if so, the second part of the test is applied to determine if the conflict actually affected the outcome of the decision. Id. at 1256.

The Eleventh Circuit applies a presumptively void standard. The plan beneficiary must demonstrate a substantial conflict of interest on the part of the plan administrator who is responsible for the determination of benefits. *Brown* at 1566. At this point the burden is shifted to the fiduciary to prove its decision was not tainted by self-interest. Id. The Ninth Circuit has employed a similar approach. *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995).

The sliding scale approach is described significantly differently by almost all circuits that apply this standard. Even more concerning is that these circuits do not always apply the standard as they describe it.

The Third Circuit uses a heightened degree of scrutiny when potentially relevant factors of conflict are present. *Pinto* at 392. The Eighth Circuit has declared this standard, among others, in part but now alleges that it applies a test of a "palpable conflict of interest" or "serious procedural irregularity" which is the cause of a serious breach of the administrator's fiduciary duty to the plan beneficiary. *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998). Similarly, the Seventh Circuit applies a standard by which it does not determine the fact that the plan administrator receives a financial benefit from denial of a claim as an automatic conflict of interest. *Mers* at 1020. The First Circuit applied a deferential standard that may not necessarily be warranted when a conflict of interest exists. *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181, 184 (1st Cir. 1998).

There are still even more different standards being applied by the Fourth, Fifth, Sixth and Tenth Circuits. A clear example of the conflict between the circuits on this issue is the application of the standard in the Petitioners' case by the Eighth Circuit as compared to the standard set out and applied in *Pinto* by the Third Circuit. *Pinto* at 393-395.

Quite simply, the application of these two different standards require two different results and magnify a clear conflict between the circuits. This area of the law is badly in need of guidance from this Court to eliminate this serious split between the circuits. The Eighth Circuit's

decision in conflict with other circuit courts of appeal, further points to the need for plenary review by this court.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 99-4315

Mary Glenn; Ernest-Jackson Lori Marshall; Lane Glenn,	*	
Appellants,	*	Appeal from the United States District Court for the Western District of Missouri
v.	*	
Life Insurance Company of North America, a Pennsylvania Stock corporation (a part of CIGNA Group Insurance),	*	
Appellee.	*	

Submitted: November 16, 2000

Filed: February 12, 2001

Before BOWMAN, FAGG, and BYE, Circuit Judges.

PER CURIAM.

After Robert Jackson died of a self-inflicted gun shot wound, his beneficiaries sought the proceeds of an accidental death insurance policy covering Jackson and

issued to Jackson's employer by Life Insurance Company of North America. The policy excludes benefits for intentionally self-inflicted injuries while sane. The Company denied coverage, concluding there was no evidence Jackson was insane at the time of his death or that his suicide was accidental. After the Company again denied the claim, the beneficiaries brought this action asserting breach of contract, vexatious refusal to pay, and a claim under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B). The district court granted summary judgment to the Company, concluding ERISA preempts the state-law breach of contract and vexatious refusal to pay claims, and the Company did not abuse its discretion in failing to pay policy proceeds.

On appeal, the beneficiaries first argue the district court committed error in applying the abuse of discretion standard of review. When, as here, the insurance company that benefits financially from the claim's denial is also the ERISA plan administrator, a less deferential standard of review may apply. See Woo v. Deluxe Corp., 144 F.3d 1157 (8th Cir. 1998). We do not automatically use a heightened standard of review any time the insurer is also plan administrator, however. See Barnhart v. UNUM Life Ins. Co. of N. Am., 179 F.3d 583, 587, 588 & n.8 (8th Cir. 1999). to obtain the less deferential standard, the beneficiaries must show, under the particular facts and circumstances of the case, that a conflict or procedural irregularity so tainted the process that it caused a serious breach of fiduciary duty. See id. at 588. The beneficiaries have failed to do so.

The beneficiaries informed the Company they believed Jackson was not sane at the time of his death, and hired Dr. William Logan to investigate the circumstances surrounding Jackson's suicide. Dr. Logan concluded "Jackson could not exercise a rational judgment on the

question of life or death." A doctor hired by the Company's attorney conducted a thorough investigation and concluded "Jackson was not insane at the time he took his own life." After considering the doctors reporters, as well as other evidence, the Company denied the claim on administrative review. The beneficiaries contend the Company should have obtained an independent expert opinion about Jackson's sanity from legal and mental health professionals. See Woo, 144 F.3d at 1161 (insurer's use of only an in-house medical reviewer amounted to a serious breach of fiduciary duty). The mere fact that the Company reached a decision contrary to the beneficiaries' medical evaluator, when the Company based its decision on substantial evidence in the record, including the report of a medical reviewer outside of the Company, does not give rise to serious doubts about whether the denial was arbitrary. See Sahulka v. Lucent Technologies, Inc., 206 F.3d 763, 768 (85h Cir. 2000). The beneficiaries have not met their burden of showing the financial conflict was connected with the denial of their claim. See id. The district court thus properly reviewed the Company's denial for abuse of discretion.

The beneficiaries also assert ERISA does not apply or preempt the state law claims. WE disagree. In their joint motion to stay the case, the beneficiaries stated, "The parties agree that the plan at issue is governed by ERISA, . . . and plaintiffs' claims are regulated by ERISA." Besides, as the district court found, the evidence shows the claims relate to an employee welfare benefit plan under ERISA, and are thus preempted. See Molasky v. Principal Mut.Life Ins.Co., 149 F.3d 881, 884 (8th Cir. 1998)(ERISA preempts claim for breach of contract); In re Life Ins. Co. of N. Am., 857 F.2d 1190, 1194-95 (8th Cir. 1988)(ERSA preempts vexatious refusal claim).

We affirm the district court.

BYE, Circuit Judge, dissenting.

The majority concludes that the plaintiff-beneficiaries failed to demonstrate circumstances sufficient to trigger a less deferential standard of review. I disagree. The Company decided to deny benefits based on the opinion of an expert hired *after* litigation commenced, and at the suggestion of defense counsel. Under these circumstances, I believe that we should apply a less deferential standard of review. Giving less deference to the conflicted decision to deny benefits, I would remand. The Company should be required to obtain a truly independent, outside medical opinion about Robert Jackson's sanity before making a benefits determination.

The procurement of independent medical review is a key factor in deciding whether we should apply a less deferential standard of review in cases where the insurer is also the ERISA plan administrator (i.e., conflicted administrator). Compare Woo v. Deluxe Corp., 144 F.3d 1157, 1161-62 (8th Cir. 1998)(applying the sliding scale standard of review where conflicted administrator did not obtain independent medical review) with Barnhart v. UNUM Life Ins. Co. of Am., 179 F.2d 583, 586 (8th Cir. 1999)(refusing to apply the sliding scale approach where conflicted administrator had both a physical therapist and physician perform independent evaluations of claimant), and Schatz v. Mut. of Omaha Ins. Co., 220 F.3d 944, 949 (8th Cir. 2000)(refusing to apply the sliding scale approach where conflicted administrator had an orthopedic specialist perform an independent medical examination of claimant).

The Company's *initial* decision to deny benefits was based solely on an in-house review of Jackson's medical records.[1] The Company's *ultimate* decision was based entirely on Dr. Harry's opinion. Dr. Harry was hired only after the beneficiaries initiated litigation in an attempt to obtain benefits. The Company admits it hired Dr. Harry at the suggestion of defense counsel. The Company acknowledges that it could have requested Unival, an outside medical consultant group, to review the file and give an independent opinion about Jackson's sanity, but the Company declined to do so.

In my view, the majority opinion sets a dangerous precedent. When a conflicted administrator finds itself in litigation after initially denying an award of benefits, it may realize that it failed to use proper judgment or thoroughly investigate the claim. In that situation, the majority" decision allows the conflicted administrator to resort to the testimony of an adversarial litigation expert to justify the earlier benefits denial. We don't normally permit fiduciaries to act like this. In the adversarial context, it would be naïve to believe that a conflicted administrator won't, inevitably, find a litigation expert to provide the scant evidence required to support a denial. Cf. Schatz, 220 F.3d at 949 (discussing the deferential standard of review).

I would require "substantial evidence bordering on a preponderance to uphold [the Company's] decision. Woo, 144 F.3d at 1162. Under the less deferential standard, I find this record insufficient to support the Company's

[1] The Company initially denied the claim because Jackson's medical records revealed no treatment for mental health problems. Dr. Logan later opined that the lack of treatment for Jackson's obsessive/compulsive disorder, avoidant personality disorder, and depression was what most likely precipitated the suicide.

denial. First, Dr. Logan opined that Jackson was insane at the time of his suicide, and I find that opinion sound. Second, I find it significant that Dr. Harry voiced no criticism of Dr. Logan's conclusions, despite Dr. Harry's adversarial role. Finally, the manner in which Dr. Harry chose to state his ultimate conclusion raises a red flag. Dr. Harry merely listed several factors indicating insanity, followed by a longer list of factors indicating sanity. Dr. Harry then concluded that, "on balance," Jackson wasn't deranged or insane at the time of his death. I question the legitimacy of what appears to be a purely quantitative approach to what is undisputedly a qualitative medical issue.

Under ERISA, a plan administrator must discharge its fiduciary "duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of *providing* benefits to participants and their beneficiaries.'" 29 U.S.C. § 1104(a)(1)(emphasis added)(internal punctuation omitted). I realize we normally view the decisions of ERISA plan administrators with a great deal of deference. But when the plan administrator doubles as the insurer, and denies benefits, we must be careful not to render § 1104(a)(1)'s directive nugatory. For this reason, as well as those expressed above, I would remand this case and require the Company to obtain and consider a truly independent medical opinion before making a decision about benefits.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

MARY GLENN, et al.,	)	
	)	
Plaintiffs,	)	No. 97-0268-CV-W-9
	)	
v.	)	
	)	
THE LIFE INSURANCE COMPANY OF NORTH AMERICA,	)	
	)	
Defendant.	)	

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Plaintiffs are the beneficiaries of any proceeds payable under an accidental death insurance policy covering decedent Robert Jackson. Plaintiffs assert three claims against defendant The Life Insurance Company of North America (LICNA). In Count I, plaintiffs assert a claim for breach of contract, in Count II, plaintiffs allege vexatious refusal to pay insurance proceeds, and in Count III, plaintiffs assert a claim under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132.

Defendant moves for summary judgment arguing that 1) ERISA preempts plaintiffs' state law claims for breach of contract and vexatious refusal to pay and 2) that there was substantial evidence to support the decision to deny benefits and that the decision was not arbitrary or capricious.

I.

STANDARD FOR SUMMARY JUDGMENT

Rule 56(c), Federal Rules of Civil Procedure, provides that summary judgment shall be rendered if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact ant that the moving party is entitled to judgment as a matter of law." In ruling on a motion for summary judgment, it is the court's obligation to view the fats in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. Adickes v. S.H. Kress & Co., 398 U.S. 144, 157, 90 S. Ct. 1598, 1608 (1970); Inland Oil and Transport Co. v. United States, 600 F.2d 725, 727-28 (8th Cir. 1979).

If there is no genuine issue about any material fact, summary judgment is proper because it avoids needless and costly litigation and promotes judicial efficiency. Roberts v. Browning, 610 F.2d 528, 531 (8th Cir. 1979); United States v. Porter, 581 F.2d 698, 703 (8th Cir. 1978). The summary judgment procedure is not a "disfavored procedural shortcut." Rather, it is "an integral part of the Federal Rules as a whole." Celotex Corp. v. Catrett, 106 S. Ct. 2548, 2555 (1986). See also City of Mt. Pleasant v. Associated Elec. Coop. , Inc., 838 F.2d 268, 273 (8th Cir. 1988). Summary judgment is appropriate against a party who fails to make a showing sufficient to establish that there is a genuine issue for trial about an element essential to that party's case, and on which that party will bear the burden of proof at trial. Celotex, 106 S. Ct. at 2553.

The moving party bears the initial burden of demonstrating by reference to portions of pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, the absence of genuine issues of material fact. However, the moving party is not required to support its motion with affidavits or other similar materials negating the opponent's claim. Id. (emphasis added).

The nonmoving party is then required to go beyond the pleadings and by affidavits, depositions, answers to interrogatories and admissions on file, designate specific facts showing that there is a genuine issue for trial. Id. A party opposing a properly supported motion for summary judgment cannot simply rest on allegations and denials in this pleading to get to a jury without any significant probative evidence tending to support the complaint. Anderson v. Liberty Lobby, Inc., 106 S. Ct. 2505, 2510 (1986).

A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Id. the evidence favoring the nonmoving party must be more than "merely colorable." Id. at 2511. When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show there is some metaphysical doubt as to the material facts. Matsushita Elec. Indus. Co. v. Zenith Radio, 106 S. Ct. 1348, 1356 (1986) (footnote omitted).

The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. Anderson, 106 S. Ct. at 2511. Essentially, the question in

ruling on a motion for summary judgment and on a motion for directed verdict is whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law. Id. at 2512.

II.

FACTS

Based on the parties' pleadings, deposition testimony, answers to interrogatories, and admissions, the following facts are undisputed or, if disputed and plaintiffs properly presented facts supporting their version of disputed facts, are presented here in the light most favorable to plaintiffs.

Decedent Robert Jackson was an employee of Hallmark Cards, Incorporated (Hallmark). As an employee of Hallmark, Jackson had an accidental death and dismemberment policy issued by LICNA.

On January 10, 1995, Jackson was found dead in his apartment from a self-inflicted gunshot wound to the head.

Plaintiffs filed a claim for benefits on February 14, 1995. LICNA denied the claim on May 25, 1995, stating that

> we did not find evidence of treatment for sanity-related conditions, or indications that Mr. Jackson was not sane at the time of his death.

> Since the policy, OK 6226 excludes payment for losses which result from intentionally self-inflicted injuries, we must deny you [sic] claim for Accidental Death benefits at this time."

On July 19, 1995, plaintiffs Mary Glenn and William Jackson sent a letter requesting an administrative review of the decision to deny benefits. In the letter, Glenn and Jackson stated their belief that Robert Jackson's "mental state was unsound, and that conditions of his employment caused his death." Plaintiffs also stated that "[n]ames of witnesses and statements can be provided upon request."

On July 27, 1995, defendant sent a letter to plaintiffs asking for "the names and addresses of the witnesses you believe might support your assertion regarding Mr. Jackson's mental state, and workplace problems, including any statements you may already have." Plaintiffs were also asked to explain the basis for their claim that Robert Jackson's mental state was unsound. Similar requests were made on September 28, 1995, October 23, 1996, and October 24, 1996. Plaintiffs made no response to defendant's requests prior to this suit being filed.

Plaintiffs filed suit in Jackson County Circuit Court on December 21, 1996, alleging breach of contract and vexatious refusal to pay. Defendants removed the case to this court on March 7, 1997.

On joint motion of the parties, this case was stayed for further review of plaintiffs' claim. During this time, plaintiffs submitted additional information for defendant to review.

Plaintiffs asked Dr. William Logan to conduct an investigation and give an opinion on the mental condition of Robert Jackson at the time of his death. Based on his investigation, Dr. Logan concluded that Jackson's "preoccupation with killing himself continued for some time prior to his death and constituted a 'morbid impulse' which he could no longer had the strength of will to resist." In Dr. Logan's opinion, Jackson "could not exercise a rational judgment on the question of life or death."

Defendant also sought an expert opinion of Jackson's mental condition at the time he died. Dr. Bruce Harry concluded that "[t]o a reasonable degree of medical certainty, that, on balance, at the time he took his own life, Mr. Jackson was not insane within the meaning of the Missouri standard as expressed in Garmon v. General American Life Insurance Company, 624 S.W.2d 42 (Mo. App. E.D. 1981)."

LINA again denied plaintiffs claim on March 20, 1998, stating that "[t]he evidence in the documents listed above supports the fact that Robert E. Jackson died as a result of suicide from a self-inflicted gunshot wound to the head, while sane. The evidence in the file does not support the allegation that Jackson was insane."

Plaintiffs filed an amended petition on September 4, 1998, adding a claim under ERISA.

III.

DEFENDANT'S ARGUMENT THAT ERISA PREEMPTS PLAINTIFFS' STATE LAW CLAIMS

Defendant argues that plaintiffs' state law claims for breach of contract and vexatious refusal to pay are preempted by the remedies available under ERISA. Plaintiffs respond that "[d]efendant has made no showing, other than simply stating it as a purported fact, that the policy in this case is part of an 'employee welfare benefit plan', [sic] as defined by ERISA."

On May 9, 1997, the parties filed with the court a joint motion to stay this case to allow defendant an opportunity to further review plaintiffs' claim. In the motion, which was signed by an attorney for the plaintiffs, the parties stated they "agree that the plan at issue is governed by ERISA, 29 U.S.C. § 1001 (et. seq.) and plaintiffs' claims are regulated by ERISA." Based on the plaintiffs' statement to the court that ERISA governs these claims, plaintiffs' state law claims are preempted by ERISA.

Even if plaintiffs had not previously conceded that the plan is governed by ERISA, I would conclude that the policy in question was part of an employee welfare benefit plan and that ERISA preempts the breach of contract claim and the vexatious refusal to pay claim. See Molasky v. Principal Mutual Life Insurance Co., 149 F.3d 881, 884 (8th Cir. 1998) (ERISA preempts Missouri state law claim for breach of contract); Vickery v. United Medical Resources, Inc., 43 F.3d 1208, 1209 (8th Cir. 1994) (ERISA preempts Missouri state law claim for vexatious refusal to pay); In

Re Life Insurance Co. of North America, 857 F.2d 1190, 1195 (8th Cir. 1988) (same).

IV.

STANDARD FOR REVEWING DECISIONS GOVERNED BY ERISA

Defendant argues that this court's review of the administrator's decision should be limited to the record before LICNA at the time of its decision and should be based on an arbitrary and capricious standard. Plaintiffs respond that the court should apply "a more penetrating standard of heightened scrutiny" because, as both plan administrator and the insurer of the benefit plan, LICNA has a conflict of interest.

The parties do not, however, make a distinction between the standard for reviewing the interpretation of plan language and the standard for reviewing factual determinations made by the plan administrator. Because the dispute in this case is over a factual determination made by defendant, the standard for reviewing factual determinations must be determined.

In the Fifth Circuit, a plan administrator's factual determinations are reviewed for abuse of discretion. See Pierre v. Connecticut General Life Insurance Co., 932 F.2d 1552, 1562 (5th Cir. 1991), cert denied, 502 U.S. 973, 112 S. Ct. 453 (1991). Other circuits review factual determinations de novo, unless the benefit plan gives the plan administrator discretionary authority. See Luby v. Teamsters Health, Welfare, and Pension Trust Funds, 944 F.2d 1176 (3rd Cir. 1991).

Apparently, the Eighth Circuit Court of Appeals would follow the Fifth Circuit and review a plan administrator's factual determinations for abuse of discretion. In Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 571 n.2 (8th Cir. 1992), the court commented that "[o]ur circuit apparently sided with those adopting the deferential standard of review." See also, McCourtney v. McKenchnie Investments, Inc., 976 F. Supp. 1259, 1262 (D. Minn. 1997) ("The dicta in Cox is helpful in suggesting the likely future direction of the Eighth Circuit on the issue."). See also Vesaars v. Hartford Accident & Indemnity Co., 124 F.3d 209 (8th Cir. 1997) (unpublished decision re-affirming decision in Cox).

However, in Woo v. Deluxe Corp., 144 F.3d 1157, 1160-61 (8th Cir. 1998), the court held that, when the insurer also serves as the plan administrator, a less deferential standard of review may be appropriate. "To obtain a less deferential review, [the plaintiff] must present material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to [the plaintiff]." Id.

I am not persuaded that a less deferential standard of review than abuse of discretion is warranted in this case. Although acting as both insurer and plan administrator creates a potential conflict of interest for LICNA, plaintiffs have not presented facts showing a serious breach of LICNA's fiduciary duty to the plaintiffs.

Plaintiffs argue that the expert relied on by defendant in denying plaintiffs' claim on March 20, 1998, was hired after this suit was filed and, therefore, "cannot reasonably be called 'independent.' " As in Woo, where a similar argument was made, I interpret this as an

allegation that LICNA did not use proper judgment or thoroughly investigate plaintiffs' claim. See Woo, 144 F.3d at 1161.

In Woo the court concluded that the defendant failed to use proper judgment by not seeking expert review of the plaintiff's claim when it "was confronted with medical evidence of an uncommon disease" and the opinions of two doctors stating that the plaintiff was disabled. Id. at 1161. Here, when confronted with Dr. Logan's conclusion that Jackson was insane at the time he committed suicide, defendant sought the expert opinion of Dr. Harry.

Plaintiffs also argue that "defendant admittedly failed to follow ERISA guidelines in reviewing plaintiffs' claims. . . ." This statement refers to the fact that defendant did not perform a review of plaintiffs' claim after the letter requesting administrative review and did not, within 120 days, inform plaintiffs why the appeal was being denied. Taylor depo. at 87, lines 9-16; 88, lines 13-24; 89, line 1. However, within 120 days defendant twice requested that plaintiffs furnish additional information supporting plaintiffs' position that Robert Jackson was insane at the time he committed suicide. July 27, 1995, letter to Mary Glenn & William Jackson; September 28, 1995, letter to Mary Glenn & William Jackson. Plaintiffs did not respond to either letter.

Therefore, plaintiffs have not presented facts supporting the conclusion that a conflict of interest or serious procedural irregularity caused a serious breach of LICNA's fiduciary duty. See Woo, 144 F.3d at 1060-61. Not having satisfied Woo's "two-part gateway requirement" for a more stringent review than abuse of

discretion, the abuse of discretion standard will be used to review factual determinations made by defendant LICNA.

V.

DEFENDANT'S ARGUMENT THAT REVIEW BY THIS COURT SHOULD BE LIMITED TO THE ADMINISTRATIVE RECORD

Defendant argues that "[r]egardless of the standard of review employed by the Court on the question of plaintiffs' entitlement to benefits, plaintiffs should be precluded from offering any evidence that was not submitted to defendant during the claim review process and prior to the time the benefits decision was made." Plaintiffs respond that defendant's motion to limit review to the administrative record "is premature at best and should not even affect the Court's consideration of the motion for summary judgment."

On the issue of whether defendant's decision to deny benefits was an abuse of discretion, the parties have not submitted any material that was not contained in the administrative record used by defendant in making its final decision. Therefore, it is not necessary to determine whether testimony, documents, or other materials not included in the administrative record should be considered.

VI.

ARGUMENT THAT ADMINISTRATOR'S DECISION SHOULD BE AFFIRMED AS A MATTER OF LAW

Defendant argues that summary judgment on plaintiff's ERISA claim is proper because defendant's "decision was reasonable and supported by the record." Plaintiffs respond that a factual dispute remains over the mental state of Robert Jackson at the time of his death and that this dispute prohibits summary judgment in defendant's favor.

Plaintiffs are correct that conflicting facts have been presented about the mental condition of Robert Jackson when he committed suicide. However, the issue in this proceeding is whether there is a dispute of material fact over whether defendant abused its discretion when it determined that Jackson was sane when he died.

The final decision to deny benefits was made by John Taylor. Taylor had been a senior life examiner in the claims division since 1991. Taylor depo. at 23-24. In reaching the decision to deny benefits, Taylor reviewed and relied upon the entire claim file, the insurance policy, a Hallmark employee benefits brochure entitled "Career Rewards," medical records from Dr. Nancy Russell, the January 10, 1995, Gladstone Department of Public Safety Incident and Crime Report, the January 10, 1995, Medical Examiner's Report and Supplemental Report #95008, the January 10, 1995, autopsy report from Dr. Bonita Peterson, the January 11, 1995, toxicology report, the September 30, 1997, report by Dr. Logan, affidavits from Pat Blair, Carl Starkey, Debbie Jackson, Marsha Gardner, and Brian Middleton, and the March 2, 1998, report by Dr. Harry.

Taylor depo. at 137, lines 8-13; Taylor letter to Walters dated March 20, 1998, at 2.

In support of the position that Jackson was insane when he committed suicide, plaintiffs point to the report prepared by Dr. Logan and the material in the claim file cited in Logan's report.

Just because there are conflicting expert conclusions and just because there are facts that could support conflicting conclusions does not create an issue for trial over whether defendant abused its discretion when it determined Jackson was sane at the time of his death. Defendant chose to rely on Dr. Harry's report that found Jackson was sane and plaintiffs have not demonstrated that doing so was an abuse of discretion. Defendant "did not abuse its discretion merely because there was evidence before it that would have supported an opposite decision." Bolling v. Eli Lilly & Co., 990 F.2d 1028, 1029-30 (8th Cir. 1993).

Also, the plaintiffs' arguments that LICNA had a conflict of interest, that LICNA only sought expert advice after this lawsuit was filed, and that LICNA did not review the claim as promptly as plaintiffs believe it should have been, do not alter the conclusion that LICNA did not abuse its discretion.

Therefore, defendant's motion for summary judgment will be granted.

VII.

PLAINTIFFS' ARGUMENT THAT MO. REV. STAT. § 376.620 PREVENTS THE DEFENDANT FROM RAISING SUICIDE AS A DEFENSE TO COVERAGE

Plaintiffs argue that defendant has not shown that Jackson contemplated suicide when he applied for the accidental death policy. Plaintiffs contend that, under Mo. Rev. Stat. § 376.620, "without such a showing, defendant has no defense to coverage."

Defendant responds that "this statute does not affect the defense that there is no accident under an accidental death policy where an insured commits suicide while not insane (sane)."

Mo. Rev. Stat. § 376.620 states that

In all suits upon policies of insurance on life hereafter issued by an company doing business in this state, to a citizen of this state, it shall be no defense that the insured committed suicide, unless it shall be shown to the satisfaction of the court or jury trying the cause, that the insured contemplated suicide at the time he made his application for the policy, and any stipulation in the policy to the contrary shall be void.

The insurance policy at issue in this case provided that

We agree to pay benefits for loss from bodily injuries:

a. caused by an accident which happens while an insured is covered by this policy; and

b. which, directly and from no other causes result in a covered loss. (See Description of Coverage.)

We will not pay benefits if the loss was caused by:

a. sickness, disease or bodily infirmity; or

b. any of the Exclusions listed on page

2.

The "Exclusions" section of the policy states:

No benefits will be paid for loss resulting from:

1. Intentionally self-inflicted injuries, or any attempt threat, while sane or insane (in Missouri, while sane).

In Miller v. Home Ins. Co., 605 S.W.2d 778, 780 (Mo. 1980), plaintiff conceded that "suicide while sane" has not been regarded in Missouri as an accidental bodily injury under an accident insurance policy. However, plaintiff contended that suicide while sane was covered by the policy in that case because an attempt was made to exclude it "[r]easoning on the premise that if excluded it was covered, plaintiff then asserts the exclusion is invalidated by our suicide statute, § 376.620." Id.

The court rejected the plaintiff's argument.

It is settled law that the phrase "accidental bodily injury" does not include suicide while sane, see Couch on Insurance 2d, § 41.196 and numerous Missouri cases cited, and we conclude that suicide while sane was not a covered risk within this group policy of insurance before us. As

there was no coverage, the effect of the exclusionary clause and of § 376.620 are irrelevant to a determination of the cause."

Id. at 780-81.

Here, plaintiffs are claiming benefits under an accident policy. Because Jackson was determined to have been sane at the time of his death, § 376.620 does not control the outcome of this case.

VIII.

CONCLUSION

Accordingly, it is ORDERED that:

1) defendant's Motion for Summary Judgment (Doc. 40) is granted;

2) plaintiffs' claim in Count I for breach of contract is dismissed with prejudice, at plaintiffs' costs;

3) plaintiffs' claim in Count II for vexatious refusal to pay is dismissed with prejudice, at plaintiffs' costs; and

4) plaintiffs' claim in Count III for wrongful denial of benefits under ERISA is dismissed with prejudice, at plaintiffs' costs.

/s/ D. Brook Bartlett
D. BROOK BARTLETT
UNITED STATES DISTRICT JUDGE

Kansas City, Missouri

November 15, 1999.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 99-4315

Mary Glenn, et al.,	*	
	*	
Appellants,	*	Order Denying Petition
	*	for Rehearing and for
v.	*	Rehearing En Banc
	*	
Life Insurance Company of North America,	*	
	*	
	*	
Appellee.	*	

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

(5128-010199)

April 23, 2001

Order Entered at the Direction of the Court:

\s\ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 99-4315WMKC

Mary Glenn, et al.,	*	
	*	
Appellants,	*	Appeal from the United
	*	States District Court for
v.	*	the Western District of
	*	Missouri
Life Insurance Company	*	
of North America,	*	
	*	
Appellee.	*	

The motion of appellants for an extension of time until 3/12/01 to file a petition for rehearing is granted.

(5276-010199)

February 23, 2001

Order entered Under Rule 27B(a):

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit